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	17E183	A. BUILDING _____ B. WING _____	C 05/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #86480. A revised copy of the deficiencies was sent to the provider on 5/12/15.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 33 residents. The sample included 3 residents, who were reviewed for resident neglect. Based on observation, record review and interview the facility failed to notify the physician of an antipsychotic medication, ordered for behaviors, not administered to 1 sampled resident. (#1)

Findings Included:

- Resident #1's annual (MDS) Minimum Data Set assessment, dated 02/18/15, indicated the resident had short and long term memory problems and severely impaired cognition with physical and verbal behaviors. The MDS also indicated the resident walked independently without an assistive device and displayed wandering behaviors, placing the resident at significant risk of getting to a potentially dangerous place.

The 02/18/15 (CAA) Care Area Assessment for behaviors indicated the resident had long standing mental health problems with behaviors and wandered and/or paced almost constantly. The CAA for behaviors also indicated the resident resisted cares and was combative towards staff.

The 02/25/15 care plan indicated the resident wandered and attempted to leave the facility almost constantly. The care plan directed staff to closely supervise the resident as possible, redirect as needed, and be aware of the resident's aggressive/combative behaviors. The

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care plan also directed staff to avoid overstimulation, maintain a calm environment and simplify tasks to avoid agitation. The care plan further directed staff to keep a safe distance from the resident when he/she was aggressive, and reapproach in a calm manner.

The 03/30/15 physician office visit note indicated the resident had progressing dementia (progressive mental disorder characterized by failing memory, confusion) with less understandable speech and intellectual function. The note also indicated the facility's staff reported the resident had wandering and/or elopement behaviors with increasing agitation and combativeness towards staff. The note further indicated the physician ordered a trial dose of Risperdal (antipsychotic medication) 0.25 milligrams (mg) every night, to see if the medication decreased the resident's behaviors.

The 03/31/15 at 3:08 AM, nurse's note indicated the resident's family member called the facility and told staff not to administer the Risperdal medication to the resident until the family member spoke to the physician.

The 04/09/15 physician order directed staff to complete a yearly (FSBS) finger stick blood sugar for the resident and asked staff to report the resident's status since initiating the antipsychotic medication therapy.

Review of the resident's medical record revealed no documentation the staff reported the resident's status to the physician, and/or the resident had not received the antipsychotic medication as ordered by the physician 11 days ago, to reduce the resident's behaviors.

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The 04/15/15 at 2:30 PM, nurse's note indicated staff notified the physician regarding the family unwilling to allow the resident to start on medication to help with behaviors until they visit with the physician. (16 days after the physican ordered the Risperdal)

Review of the March and April 2015 (MAR) Medication Administration Record revealed staff held the resident's Risperdal 0.25 mg for diagnosis of dementia with behaviors, from 03/30/15 to 04/15/15 (16 days).

On 05/06/15 at 2:10 PM, observation revealed the resident ambulated independently to the east exit door and activated the wanderguard alarm. Continued observation revealed 2 staff responded and redirected the resident away from the door.

On 05/06/15 at 3:12 PM, Nurse C stated the resident had severely impaired cognition, wandered or paced throughout the facility and had a wanderguard alarm. Nurse C also stated staff redirected the resident constantly and the resident had frequent behaviors of resisting cares and combativeness with staff. Nurse C stated the physician ordered an antipsychotic medication for the resident's behaviors, staff held the medication due to family concerns, and this nurse was not aware if staff notified the physician about not administering the medication to the resident.

On 05/06/15 at 3:52 PM, Administrative Nurse D stated staff reported the resident's constant wandering and frequent combative behaviors to the physician and the physician ordered an antipsychotic medication (Risperdal) to decrease

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F 157	Continued From page 4 the resident's behaviors. Nurse D stated staff held the antipsychotic medication due to family concerns, and staff did not immediately notify the physician. The facility failed to notify the physician of an antipsychotic medication, ordered for behaviors, not administered to Resident #1.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		

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The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 33 residents, of which 3 residents were reviewed for elopement risk. Based on observation, record review, and interview the facility failed to report an elopement and unwitnessed fall to the State survey and certification agency within 24 hours for 1 of 3 sampled residents. (#1)

Findings included:

- On 04/16/15 at 10:32 PM, nurse's note indicated Resident #1 exited the facility, on 04/15/15 at 05:15 PM, and fell in a hospital hallway. The nurse's note indicated staff assessed the resident's head abrasion and sent the resident to the emergency room for evaluation and treatment.

Review of the state agency's Complaint/Incident Investigation Report for Complaint #86480 indicated the facility reported the elopement and fall to the state agency on 04/28/15 (13 days after the incident occurred).

On 05/06/15 at 1:20 PM, Administrative Staff E stated he/she was on leave at the time of the incident and reported the elopement to the state

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F 225	Continued From page 6 agency the first day he/she returned to work. Administrative Staff E stated the facility had no system in place for other staff to report incidents to the state agency. On 05/06/15 at 3:52 PM, Administrative Nurse D stated the facility should have a system in place to report incidents to the state agency within 24 hours as directed by the facility's policy. The facility's 12/02/09 abuse and neglect policy directed the risk manager to report alleged incidents to the appropriate state agency within 24 hours. The facility failed to report an elopement and unwitnessed fall to the State survey and certification agency within 24 hours.	F 225		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility had a census of 33 residents. The sample included 3 residents, who were reviewed for resident neglect. Based on observation, record review and interview, the facility failed to provide medication for behaviors as ordered by the physician and accurately monitor behaviors	F 309		

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for 1 sampled resident. (#1)

Findings Included:

- Resident #1's annual (MDS) Minimum Data Set assessment, dated 02/18/15, indicated the resident had short and long term memory problems and severely impaired cognition with physical and verbal behaviors. The MDS also indicated the resident walked independently without an assistive device and displayed wandering behaviors, placing the resident at significant risk of getting to a potentially dangerous place.

The 02/18/15 (CAA) Care Area Assessment for behaviors indicated the resident had long standing mental health problems with behaviors and wandered and/or paced almost constantly. The CAA for behaviors also indicated the resident resisted cares and was combative towards staff.

The 02/25/15 care plan indicated the resident wandered and attempted to leave the facility almost constantly. The care plan directed staff to closely supervise the resident as possible, redirect as needed, and be aware of the resident's aggressive/combative behaviors. The care plan also directed staff to avoid overstimulation, maintain a calm environment and simplify tasks to avoid agitation. The care plan further directed staff to keep a safe distance from the resident, when he/she was aggressive and reapproach in a calm manner.

The 03/30/15 physician office visit note indicated the resident had progressing dementia (progressive mental disorder characterized by failing memory, confusion) with less

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understandable speech and intellectual function. The note also indicated the facility's staff reported the resident had wandering and/or elopement behaviors with increasing agitation and combativeness towards staff. The note further indicated the physician ordered a trial dose of Risperdal (antipsychotic medication) 0.25 milligrams (mg) every night, to see if the medication decreased the resident's behaviors.

The 03/31/15 at 3:08 AM, nurse's note indicated the resident's family member called the facility and told staff not to administer the Risperdal medication to the resident until the family member spoke to the physician.

The 04/09/15 physician order directed staff to complete a yearly (FSBS) finger stick blood sugar for the resident and asked staff to report the resident's status since initiating the antipsychotic medication therapy.

Review of the resident's medical record revealed no documentation the staff reported the resident's status to the physician, and/or the resident had not received the antipsychotic medication as ordered by the physician 11 days ago, to reduce the resident's behaviors.

The 04/15/15 at 2:30 PM, nurse's note indicated staff notified the physician regarding the family unwilling to allow the resdient to start on medication to help with behaviors until they visit with the physician (16 days after the physician ordered the Risperdal)

Review of the March and April 2015 (MAR) Medication Administration Record revealed staff held the resident's Risperdal 0.25 mg for

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diagnosis of dementia with behaviors, from 03/30/15 to 04/15/15 (16 days).

The facility's March, April and May 2015 Behavior/Intervention Flow Records directed the staff to record and monitor the resident's aggressive behaviors every shift (day, evening and night). Review of the behavior records revealed the following:
1) One behavior recorded in March out of 93 shifts
2) Two behaviors recorded in April out of 90 shifts
3) One behavior recorded in May out of 16 shifts
The staff recorded 4 behaviors on a possible 199 shifts.

On 05/06/15 at 2:10 PM, observation revealed the resident ambulated independently to the east exit door and activated the wanderguard alarm. Continued observation revealed 2 staff responded and redirected the resident away from the door.

On 05/06/15 at 1:47 PM, Nurse Aide A stated the confused resident, walked without an assistive device, had a wanderguard alarm and frequently tried to exit the building. Nurse Aide A stated the resident often became agitated and combative when staff attempted to redirect the resident and staff should document the resident's behaviors at the end of each shift.

On 05/06/15 at 3:12 PM, Nurse C stated the resident had severely impaired cognition, wandered or paced throughout the facility and had a wanderguard alarm. Nurse C also stated staff redirected the resident constantly and the resident had frequent behaviors of resisting cares and combativeness with staff. Nurse C stated the

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physician ordered an antipsychotic medication for the resident's behaviors, staff held the medication due to family concerns, and this nurse was not aware if staff notified the physician about not administering the medication to the resident. Nurse D further stated the certified nurse aides recorded the resident's behaviors every shift.

On 05/06/15 at 3:29 PM, Nurse Aide B stated the confused resident had a wanderguard, wandered and/or paced constantly and tried to exit the facility everyday. Nurse Aide B stated staff redirected the resident frequently and most times the resident was agitated and combative towards staff. Nurse Aide B further stated the staff should document the resident's behaviors at the end of each shift on the flow sheet.

On 05/06/15 at 3:52 PM, Nurse D stated staff reported the resident's constant wandering and frequent combative behaviors to the physician and the physician ordered an antipsychotic medication (Risperdal) to decrease the resident's behaviors. Nurse D stated staff held the antipsychotic medication for several weeks, due to family concerns, and staff did not notify the physician about the resident never receiving his/her antipsychotic medication. Nurse D further stated staff had not accurately recorded the resident's frequent behaviors on the Behavior Flow Record.

The facility failed to provide medication for behaviors as ordered by the physician and accurately monitor behaviors for Resident #1.